STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155377		X2) MULTIPLE CO A. BUILDING B. WING STREET	ONSTRUCTION 00 ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED 08/14/2013	
	PROVIDER OR SUPPLIER JR CROSSING	707 S J	IACKSON PARK DR DUR, IN 47274		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F000000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00128887 and IN00130258. This visit was in conjunction with the Investigation of Complaints IN00133821 and IN00134053. Complaint IN00128887 - Substantiated. Federal/state deficiencies related to the allegations are cited at F225, F226, and F246. Complaint IN00130258 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: August 5, 6, 7, 8, 9, 12, 13, and 14, 2013. Facility number: 000272 Provider number: 155377 AIM number: 100274710 Survey team: Diana Sidell RN, TC Sunny Jungclaus RN Jennifer Carr RN Angel Tomlinson RN (August 5, 6, 7, and 8, 2013)	F000000	The facility repectfully request paper review IDR for tag F 22 225, F 226, F 279, F 281, F 5 The facility has evidence for the following tags to support the deficiencies should not have the sited.	4, F 14. he	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000272

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Facility ID:

Page 1 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155377		LDING	NSTRUCTION 00	(X3) DATE COMPI 08/14		
	PROVIDER OR SUPPLIER		707 S J	ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR DUR, IN 47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)	BE	(X5) COMPLETION DATE
	findings cited in IAC 16.2. Quality review	type: sample: 2 cies reflect state n accordance with 410				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 2 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155377	B. WING	08/14/2013	
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	ER		JACKSON PARK DR	
SEYMOU	JR CROSSING			DUR, IN 47274	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F000224 SS=D	483.13(c) PROHIBIT				
	RIATN	IT/NEGLECT/MISAPPROP			
	I -	t develop and implement			
		and procedures that prohibit			
		eglect, and abuse of			
		isappropriation of resident			
	property.	ord review, observation,	F000224	F 224 PROHIBIT	09/06/2013
		,	F000224	MISTREATMENT/NEGLECT/	
		the facility failed to		APPROPRIATION The facilit	-
		dent remained free from		repectfully requests paper rev	•
		one resident had		IDR for tag F 224. The facility	
		patches removed. This		evidence for the following tags	• • • • • • • • • • • • • • • • • • •
	affected 1 of 9	residents who met the		support the deficiencies should	
	criteria for abu	use. (Resident #C)		not have been sited. The facili must develop and implement	
	Findings inclu	de:		written policies and procedure that prohibit mistreatment, neglect, and abuse of resident	
		C's record was		and misappropriation of reside	
	reviewed on 8	3/8/13 at 3:12 p.m. The		property. What corrective	for
	record indicate	ed Resident #C was		action(s) will be accomplished those residents found to have	IUI
	admitted with	diagnoses that		been affected by the deficient	
	included, but	were not limited to,		practice? * Resident #C was	not
	diabetes, high	blood pressure,		harmed by alleged deficient	
	backache, cer	rebral vascular disease,		practice. * All staff inserviced of	on
		airment, chronic back		misappropriation of resident	
		ependent diabetes		property and abuse directly af incident occurred on July 19,	er
	•	eimer's disease, lumbar		2013. *Resident #C Fentanyl	
	· · · · · · · · · · · · · · · · · · ·	s, peripheral edema,		patches are checked for	
		insomnia, depression,		placement every shift How wi	II
	_	mood disturbance, and		you identify other residents	
		•		having the potential to be affect	
	chronic pain s	syndrome.		by the same deficient practice	
				and what corrective action will taken. * Residents who resid	
	1	inimum Data Set		this facility have the potential t	
	Assessment (MDS), dated 6/1/13,		be affected by the alleged	`
1				,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 3 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE SU	RVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPLET	ED
		155377		LDING	-	08/14/20	013
			B. WIN		ADDRESS CITY STATE ZIR CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
05/4/01	ID ODOOOINO				JACKSON PARK DR		
SEYMOU	JR CROSSING			SEYMO	DUR, IN 47274		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated Resi	dent #C had severe			deficient practice. * All staff		
	impairment in	cognitive skills for daily			inserviced by the Director of		
	-	ng and was on a			Nursing and/or designee on		
		n medication regimen.			misappropriation of resident		
	Scrieduled pail	Tilledication regimen.			property and abuse directly af	ter	
	.				incident occurred on July 19,		
		capitulation orders			2013 and again on August 27 2013 *Director of Nursing and		
		through 7/31/13			designee conducted an audit		
	indicated an o	rder for Fentanyl 75			all narcotic patches to ensure		
	micrograms (n	ncg) per hour, apply 1			were in place per physician's		
	patch topically	every 72 hours for			order What measures will be	Э	
	· ·	art date of 4/17/13.			put into place or what systemi	С	
	pain, mara a	art date or 17 17 10.			changes you will make to ens	ure	
	A Dhygigian's	talanhana ardar datad			that the deficient practice doe	S	
	1	telephone order, dated			not recur? * All staff inservice		
	,	me written on the order)			by the Director of Nursing and		
		order Fentanyl Patch 75			designee on misappropriation		
	mcg." This or	der indicated a care			resident property and abuse a	πer	
	plan update of	: "Patch mistakenly			incident occurred on July 19, 2013 and again on August 27		
	removed".				2013 * Director of Nursing and		
					designee will complete 100%	2/01	
	A Physician's	telephone order			audit on all narcotic patches a	nd	
	1	ted 7/16/13 indicted:			initiate checks every shift to		
					ensure placement *Inservicin	g	
		ation. (1) Fentanyl 75			for all new staff over		
		Apply q (every) 3			abuse/misappropriation of		
		oppsite (clear adhesive			resident funds/property was	_	
	,	itch. DX (diagnosis):			conducted on August 27, 2013		
	Chronic Back	Pain. (2) [change]			and will be completed upon hi		
	Seroquel DX:	to Dementia [with]			and on annual basis by Direct of Nursing and/or designee		
) [check] placement [of]			will the corrective action(s) be		
	patch q shift."	, , , , , , , , , , , , , , , , , , , ,			monitored to ensure the defici		
					practice will not recur, i.e., wh		
	A Physician's	tolonhono order datad			quality assurance program w		
	1	telephone order dated			be put into place? * An Abus	е	
		p.m., indicated an			Prohibition and Investigation (
	order for "1X F				tool will be utilized by Director		
	replacement."	This order had a			Nursing and/or designee weel	-	
	notation of "cla	arification" written below			4 weeks, monthly x 2 months	and	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 4 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155377	B. WIN			08/14/	2013
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CEVMOL	ID CDOCCING				ACKSON PARK DR		
	JR CROSSING			SETIVIC	DUR, IN 47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFT ING INFORMATION)		TAG		the	DATE
TAG	the order. A Physician's to 7/19/13 at 10:3 "Fentanyl patch (and) Keep sch (hours) starting included a care patch off, Replapain." A reportable in misappropriation provided by the Services on 8/8 incident was daindicated, but wo "Resident [#C] Patch 75 mcg. 7/17/13 at 8am on 7/18/13 at 2 have fallen off. reapply patch or reapplied at 3:3 (clear adhesive place on mid better the services on mid better the services on mid better the services of the services o	on of property was a Director of Health 2/13 at 12:23 p.m. The ated 7/19/13 and was not limited to: has order for Fentanyl Last changed on patch found missing 2:20 p.m. Suspected to Order received to		TAG	quarterly X1 for at least 6 mon * Audit tools will be submitted the CQI committee and action plans will be developed as needed if threshold of 100% is not met.	ths to	DATE
	-	on 7/19/13 at 6:20 am					
	_	." The DHS indicated					
	,	g was reviewed and all					
		working during the					
	time frame who	•					
		nissing were tested for					
	drugs.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 5 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIH	LDING	00	COMPL	ETED
		155377	A. BUI B. WIN			08/14/	2013
		1	b. Wilv		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	R			ACKSON PARK DR		
SEYMOL	JR CROSSING				OUR, IN 47274		
				<u> </u>	7013, 117 17 27 1		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DETCHENCT)		DATE
		as observed on 8/7/13					
	· ·	alking around with her					
		esident could speak to					
		ry confused, and had					
	no indications	of being in pain. She					
	was very calm	, and had no facial					
	grimaces nor g	guarding of any parts of					
	her body.						
	_						
	2. A reportable	e incident of an					
	•	esident to resident					
	•	vided by the Director of					
		es on 8/13/13 at 10:46					
		lent, that involved					
		nd Resident #M, had					
		10/13 at 3:30 p.m. The					
		- · · · · · · · · · · · · · · · · · · ·					
		separated, the DNS					
		Director notified, and					
	l '	pervision was initiated					
		#L. The incident was					
		nd the DHS provided a					
		nat indicated the					
	incident was re	eported to the ISDH on					
	8/11/13 at 12:1	12 p.m., which was					
	approximately	21 hours after the					
	incident occurr	red.					
	3. An investiga	ation of an allegation of					
		it abuse was provided					
		of Health Services on					
	l •	16 a.m. The incident					
		#24, had occurred on					
		,					
		a.m., and indicated:					
	· •	staff #1 (QMA #24)					
	pushed back F	Resident #K's head and					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 6 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155377	A. BUII B. WIN	LDING	00	COMPLETED 08/14/2013	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ACKSON PARK DR		
SEYMOU	IR CROSSING			SEYMO	OUR, IN 47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
mo		t's time to eat" then		1710	<u> </u>		DATE
	•	nt #J and stated, "I					
		to feed you so you					
		ourself. Type of					
	· ·	Residents were					
		no injuries noted"					
		n was begun and this					
	_	ported to the ISDH on					
	7/27/13 at 2:55	p.m., which was					
	almost 6 hours	later.					
	During an inter-	view on 8/14/13 at					
	10:36 a.m., the	DHS indicated she					
	•	egation of abuse very					
	_	employee, QMA #24					
		re and did not have					
		against her. The DHS					
		nvestigates by getting					
		ule out the allegation,					
		neir tone was rough or					
		trued as rough, or were					
		misunderstanding.					
		ted the two CNA's did					
	-	he supervisor until she stressed the					
		eporting immediately					
	-	ne abuse inservices.					
	WHICH SHE GIG II	TO GOUGO ITTOO! VICCO.					
	4. An investiga	ition of a reportable					
	_	aff to resident abuse					
	_	y the DHS on 8/8/13 at					
	•	investigation indicated					
		ember of a discharged					
	-	ent #A) had reported					
		ne facility on 11/29/12					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 7 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

	OF OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155377	B. WIN	IG		08/14/	2013
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ACKSON PARK DR		
SEYMOL	JR CROSSING			SEYMO	DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		ing with care", and					
	_	h and rude. Resident					
	#A had been d	ischarged in 9/2013.					
	_	view on 8/8/13 at 3:20					
		indicated the facility					
	got a letter fror	n a resident's family					
		/29/12, that contained					
	a list of formal	concerns. She					
	indicated she v	vent through the entire					
	letter and inves	stigated all the					
	allegations, ga	ve each allegation a					
	number and pu	it in what they did to					
	correct it if it wa	as substantiated. The					
	DHS indicated	she was a consultant					
	at that time and	d assisted the					
	Executive Dire	ctor, (ED) who is no					
	longer at the fa	cility, along with the					
	Director of Hea	Ilth Services at that					
	time. She indid	cated she didn't know if					
	the ED got bac	k with the mother, but					
	they let the oth	er agency involved					
		e results, because the					
		ad sent a letter to find					
		vere going to do about					
	•	ed it like a legal matter.					
	,	longer employed, and					
	the other is still						
		y of a letter, that had					
		ne former ED to the					
	_	with an attachment with					
		gathered from the					
	investigation.	g					
	During an inter	view on 8/14/13 at					
							<u>ı</u>

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 8 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

f '		(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155377	B. WIN	G		08/14/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
05/4401	ID ODGGGING				ACKSON PARK DR		
SEYMOU	JR CROSSING			SEYMO	DUR, IN 47274		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	• •	DHS indicated they					
		confirmation the					
	_	I been reported to the					
		r agencies, so they					
		d reported this on					
	8/14/13 at 5:01	p.m.					
		'Abuse Prohibition,					
		Investigation" policy					
	-	, was provided by the					
		ctor on 8/12/13 at					
	11:04 a.m. The	e policy indicated, but					
		to, "It is the policy of					
	American Seni	or Communities to					
	protect residen	ts from abuse					
	including physi	cal abuse, sexual					
	abuse, verbal a	abuse, mental abuse,					
	neglect, involui	ntary seclusion, and					
	misappropriation	on of resident property					
	and/or fundsI	Misappropriation of					
	Resident Fund	s or Property - the					
	deliberate misp	placement, exploitation,					
	or wrongful ten	nporary or permanent					
	use of a reside	nt's belongings or					
	money without	the resident's					
	consent1. Aı						
		vill not permit residents					
		I to abuse by anyone,					
	including emplo						
	residents"	• • • • • • • • • • • • • • • • • • •					
	22.2.2						
	3.1-27(a)(3)						
	3.1-28(a)						
	5.1 <u>20(u)</u>						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 9 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155377	A. BUILD B. WING		00	COMPL 08/14/	ETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR						
SEYMOU	R CROSSING			SEYMO	OUR, IN 47274				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID EFIX ΓAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 10 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII DING	00	COMPLETED
		155377	A. BUILDING		08/14/2013
			B. WING	ADDRESS CITY STATE ZIR CORE	
NAME OF P	ROVIDER OR SUPPLIER	1		ADDRESS, CITY, STATE, ZIP CODE	
05)/1401	ID 00000N10			ACKSON PARK DR	
SEYMOL	JR CROSSING		SEYMO	DUR, IN 47274	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F000225	483.13(c)(1)(ii)-(ii	ii). (c)(2) - (4)			
SS=E	INVESTIGATE/R				
	ALLEGATIONS/II				
		not employ individuals who			
	have been found				
	neglecting, or mis	streating residents by a			
	court of law; or ha	ave had a finding entered			
	into the State nur	se aide registry concerning			
	abuse, neglect, m	nistreatment of residents or			
		of their property; and report			
		has of actions by a court of			
	_	nployee, which would			
		s for service as a nurse aide			
or other facility staff to the State nurse aide					
	registry or licensi	ng authorities.			
	The facility must	ongure that all alleged			
	-	ensure that all alleged ng mistreatment, neglect, or			
		injuries of unknown source			
		ation of resident property			
	are reported imm				
		he facility and to other			
		lance with State law			
		ed procedures (including to			
		and certification agency).			
		3 ,			
	The facility must I	have evidence that all			
	alleged violations	are thoroughly			
	investigated, and	must prevent further			
	potential abuse w	hile the investigation is in			
	progress.				
		investigations must be			
		dministrator or his			
		sentative and to other			
		lance with State law			
	(including to the S				
		cy) within 5 working days of			
		if the alleged violation is ate corrective action must			
	be taken.	ite corrective action must			
	De laken.		F000225	F 225 INVESTIGATE/REPOR	T 09/06/2013
			1.000772	1 ZZO INVESTIGATE/REPUR	09/00/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 11 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nn.a	00	COMPL	ETED
		155377		LDING		08/14/	2013
			B. WIN	_	ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
05/4401	ID ODOOOINO				ACKSON PARK DR		
SEYMOU	JR CROSSING			SEYMO	DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Based on reco	rd review and			ALLEGATIONS/INDIVIDUALS	3	
	interview, the f	acility failed to			The facility repectfully request		
		port allegations of			paper review IDR for tag F 22		
	1	tate Agency. This			The facility has evidence for the	ne	
		residents reviewed			following tags to support the		
					deficiencies should not have be sited. The facility must ensure		
		iteria for abuse.			that all alleged violations invol		
	(Residents #C,	, L, M, J, K, and A)			mistreatment, neglect, or abus	•	
					including injuries of unknown	,	
	Findings includ	le:			source and misappropriation of	of	
					resident property are reported		
	1. A reportable	e incident of			immediately to the administrat	or	
		on of property was			of the facility and to other offic	ials	
		e Director of Health			in accordance with State law		
	l ·				through established procedure		
		9/13 at 12:23 p.m. The			(including to the State survey	and	
		ated 7/19/13 and			certification agency. What		
		was not limited to:			corrective action(s) will be accomplished for those reside	nte	
	"Resident [#C]	has order for Fentanyl			found to have been affected b		
	Patch 75 mcg.	Last changed on			the deficient practice?	J	
	7/17/13 at 8am	n, patch found missing			* Resident #C, L, M, J, K, and	Α	
	on 7/18/13 at 2	2:20 p.m. Suspected to			were not harmed by alleged		
		Order received to			deficient practice. * All staff		
	reapply patch				inserviced on abuse policy and		
		30pm with tegaderm			procedure abuse on August 2	-	
	1	-			2013. How will you identify of		
		e) covering to keep in			residents having the potential		
	'	ack. Checked at 10pm			be affected by the same defici practice and what corrective	ent	
		ted still in place. Patch			action will be taken. * Reside	ents	
	found missing	on 7/19/13 at 6:20 am			who reside in this facility have		
	during check	." The DHS indicated			potential to be affected by the		
	_	ng was reviewed and all			alleged deficient practice. * A		
		working during the			staff inserviced by the Director		
	time frame when the Fentanyl				Nursing and/or designee on		
		•			abuse policy and procedure a		
	patches went missing were tested for				reporting immediately on Augu		
	drugs.				27, 2013 What measures w		
					be put into place or what syste		
	I On 8/13/13 at ⁻	10:46 a.m., the Director			changes you will make to ensi	ure	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIH	DDIC	00	COMPL	ETED
		155377	A. BUII B. WIN			08/14/	2013
			b. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ACKSON PARK DR		
SEVMOI	JR CROSSING				OUR, IN 47274		
SETIMOL	JK CKOSSING			SETIVIC	JUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ces (DHS) provided an			that the deficient practice does		
	e-mail confirma	ation that indicated the			not recur? * All staff inservice		
	incident of the misappropriation of				by the Director of Nursing and designee on abuse policy and		
	Resident #C's Fentanyl patches were				procedure and reporting		
	reported to the ISDH on 7/19/13 at				immediately on August 27, 20	13	
	2:33 p.m. which was over 24 hours				* Executive Director and/or		
	from when the patch was found				designee will place guide at ea	ach	
	missing on 7/1	•			nurses' station regarding		
		6/13.			abuse/neglect/misappropriation		
					resident property or funds/inju	ries	
	A reportable incident of an allegation of resident to resident				of unknown origin with		
					instructions to complete the guide. Information from the gu	iide	
	abuse was pro	vided by the Director of			will then be relayed to Executi		
	Health Service	s on 8/13/13 at 10:46			Director and/or designee whic		
	a.m. The incid	ent, that involved			will allow Executive Director		
	Resident #L ar	nd Resident #M, had			and/or designee to report		
		10/13 at 3:30 p.m. The			immediately to ISDH *Inservic	ing	
		separated, the DNS			for all new staff over		
		Director notified, and			abuse/misappropriation of		
		pervision was initiated			resident funds/property was	,	
		#L. The incident was			conducted on August 27, 2013 and will be completed upon hi		
					and on annual basis by Direct		
	_	nd the DHS provided a			of Nursing and/or designee		
		at indicated the			will the corrective action(s) be		
		ported to the ISDH on			monitored to ensure the defici	ent	
	8/11/13 at 12:1	2 p.m., which was			practice will not recur, i.e., who		
	approximately	21 hours after the			quality assurance program w		
	incident occurr	ed.			be put into place? * An Abus		
					Prohibition and Investigation (tool will be utilized by Director		
	3. An investiga	ation of an allegation of			Nursing and/or designee week		
	_	t abuse was provided			4 weeks, monthly x 2 months		
		of Health Services on			quarterly X1 for at least 6 mor		
	_				* Audit tools will be submitted		
	8/13/13 at 10:46 a.m. The incident involved QMA #24, had occurred on				the CQI committee and action		
					plans will be developed as		
		a.m., and indicated:			needed if threshold of 100% is	3	
	•	staff #1 (QMA #24)			not met.		
	I pushed back R	Resident #K's head and					

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155377				LDING	NSTRUCTION 00	(X3) DATE COMPL 08/14/	ETED
	PROVIDER OR SUPPLIER		p. 11.	STREET A	ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR DUR, IN 47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	went to Reside don't have time need to feed your Injury/Injuries: assessed and an investigation incident was referred to feed your Injury/Injuries: assessed and an investigation incident was referred to feed and the takes every allowed and the seriously. The had worked he any allegations indicated she in statements to rean and checks if the was it miscons the employees. She also indicated not report it to feed to feed any allegation of state was provided to feed and the feed and th	t's time to eat" then nt #J and stated, "I to feed you so you burself. Type of Residents were no injuries noted" In was begun and this sported to the ISDH on p.m., which was later. View on 8/14/13 at to DHS indicated she egation of abuse very employee, QMA #24 are and did not have against her. The DHS investigates by getting fulle out the allegation, heir tone was rough or trued as rough, or were misunderstanding. In a stressed the reporting immediately the abuse inservices. Action of a reportable aff to resident abuse by the DHS on 8/8/13 at investigation indicated the facility on 11/29/12					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 14 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

	OF OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155377	B. WIN	IG		08/14/	2013
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ACKSON PARK DR		
SEYMOL	JR CROSSING			SEYMO	DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		ing with care", and					
	_	h and rude. Resident					
	#A had been d	ischarged in 9/2013.					
	_	view on 8/8/13 at 3:20					
		indicated the facility					
	got a letter fror	n a resident's family					
		/29/12, that contained					
	a list of formal	concerns. She					
	indicated she v	vent through the entire					
	letter and inves	stigated all the					
allegations, gave each allegation a							
	number and pu	it in what they did to					
	correct it if it wa	as substantiated. The					
	DHS indicated	she was a consultant					
	at that time and	d assisted the					
	Executive Dire	ctor, (ED) who is no					
	longer at the fa	cility, along with the					
	Director of Hea	Ilth Services at that					
	time. She indid	cated she didn't know if					
	the ED got bac	k with the mother, but					
	they let the oth	er agency involved					
		e results, because the					
		ad sent a letter to find					
		vere going to do about					
	•	ed it like a legal matter.					
	,	longer employed, and					
	the other is still						
		y of a letter, that had					
		ne former ED to the					
	_	with an attachment with					
		gathered from the					
	investigation.	g					
	During an inter	view on 8/14/13 at					
							<u>ı</u>

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 15 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155377	B. WIN	G		08/14/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CEVMOL	ID CDOSSING				ACKSON PARK DR		
	JR CROSSING			l	DUR, IN 47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG		DHS indicated they	+	TAU			DATE
	•	confirmation the					
		been reported to the					
	_	r agencies, so they					
		d reported this on					
	8/14/13 at 5:01	-					
	0/1 - /10 at 0.01	γ					
	A policy titled	'Abuse Prohibition,					
		Investigation" policy					
		, was provided by the					
Executive Director on 8/12/13 at							
11:04 a.m. The policy indicated, but							
	was not limited to, "It is the policy of						
	American Senior Communities to						
	protect residen						
	•	cal abuse, sexual					
		abuse, mental abuse,					
	•	ntary seclusion, and					
		on of resident property					
		1. American Senior					
	Communities v	vill not permit residents					
		I to abuse by anyone,					
	including emplo	oyees, other					
	residents5.						
	allegations/abu	se must be reported to					
	the Executive [Director immediately,					
	and to the resid	dent's representative					
	(sponsor, respo	onsible party) within 24					
	hours of the re	port7. The Executive					
	Director/design	ee will report all					
	unusual occurr	ences, which include					
	allegations of a	buse, immediately, to					
	the Long Term	Care Division of the					
	Indiana State D	Department of					
	HealthCopies	s of the completed					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 16 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIP	LE CO		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	
		155377	B. WING			08/14/	2013
NAME OF P	PROVIDER OR SUPPLIEF	2			DDRESS, CITY, STATE, ZIP CODE		
CEVMOL	ID CDOCCINIC				ACKSON PARK DR		
	JR CROSSING			YIVIO	UR, IN 47274		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	1	ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAC		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
TAG			TAC	-	BEITELEVETY		DATE
	_	nust also be sent to					
Adult Protective Services, Ombudsman, and Director of							
	Operations"						
	Operations						
	This Federal to	an relates to Complaint					
	This Federal tag relates to Complaint IN00128887.						
	11400120001.						
	3.1-28(c)						
	(o)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 17 of 77

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155377	B. WIN			08/14/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			707 S J	ACKSON PARK DR		
	IR CROSSING			SEYMO	OUR, IN 47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000226 SS=E	483.13(c) DEVELOP/IMPLN ETC POLICIES The facility must of written policies are mistreatment, negresidents and mister property. Based on reconsinterview, the facility must of the procedures registrated allegations reported immerother agencies residents review reporting. (Restand A) Findings included 1. A reportable misappropriation provided by the Services on 8/8 incident was daindicated, but we will be reapply patch of the proposed at 3.5 and 7/18/13 at 8 amon 7/18/13 at 8 amon 7/18/13 at 2 have fallen off. reapply patch of reapplied at 3.5 and 2.5 are policided at 3.5	develop and implement and procedures that prohibit glect, and abuse of sappropriation of resident ard review and acility failed to a policies and parding reporting, in a of abuse were not diately to the ISDH and a This affected 6 of 9 wed for abuse sidents #C, L, M, J, K, de: Director of Health 19/13 at 12:23 p.m. The ated 7/19/13 and was not limited to: has order for Fentanyl Last changed on a patch found missing at:20 p.m. Suspected to Order received to a 1. Patch was 30 pm with tegaderm	F00	0226	F 226 DEVELOP/IMPLEMENT ABUSE/NEGLECT,ETC POLICIES The facility repectfurequests paper review IDR for F 226. The facility has evidence for the following tags to support the deficiencies should not have been sited. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. What corrective action(s) will be accomplished those residents found to have been affected by the deficient practice? * Resident #C, L, MK, and A were not harmed by alleged deficient practice. * All staff inserviced by the Director Nursing and/or designee on abuse policy and procedure ar reporting immediately on Augu 27, 2013 How will you identify other residents having the potential to be affected by the same deficient practice and wh corrective action will be taken. Residents who reside in this facility have the potential to be affected by the alleged	for for at the standard standa	09/06/2013
	(clear adhesive	e) covering to keep in ack. Checked at 10pm			be affected by the alleged deficient practice. * All staff inserviced by the Director of		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 18 of 77

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CON	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		155377	A. BUILDIN	G		08/14/	2013
		100017	B. WING			00/11/	2010
NAME OF I	PROVIDER OR SUPPLIE	ER			DDRESS, CITY, STATE, ZIP CODE		
					ACKSON PARK DR		
SEYMOL	JR CROSSING		SE	EYMO	UR, IN 47274		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREI	FIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TA	\G	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	and was report	rted still in place. Patch			Nursing and/or designee on		
	found missing	on 7/19/13 at 6:20 am			abuse policy and procedure a		
	during check				reporting immediately on Augu		
	during oncor	•••			27, 2013 What measures wi		
	0 - 0/40/40 -4	40:40 the Discrete			be put into place or what syste		
		10:46 a.m., the Director			changes you will make to ensu		
		vices (DHS) provided an			that the deficient practice does		
	e-mail confirm	nation that indicated the			not recur? * All staff inservice		
	incident of the	misappropriation of			by the Director of Nursing and designee on abuse policy and		
		Fentanyl patches was			procedure and reporting		
		e ISDH on 7/19/13 at			immediately on August 27, 20	13	
		ch was over 24 hours			* Executive Director and/or	.0	
	•				designee will place guide at ea	ach	
		e patch was found			nurses' station regarding		
	missing on 7/	18/13.			abuse/neglect/misappropriation	n of	
					resident property or funds/inju		
	2. A reportab	le incident of an			of unknown origin with		
		esident to resident			instructions to complete the		
	_	ovided by the Director of			guide. Information from the gu		
	· ·	es on 8/13/13 at 10:46			will then be relayed to Executi		
					Director and/or designee whic	h	
		dent involved Resident			will allow Executive Director		
		ent #M and had			and/or designee to report		
	occurred on 8	/10/13 at 3:30 p.m. The			immediately to ISDH *Inservic for all new staff over	ing	
	incident was in	nvestigated and the			abuse/misappropriation of		
	DHS provided	l a dated e-mail that			resident funds/property was		
		ncident was reported to			conducted on August 27, 2013	3	
		3/11/13 at 12:12 p.m.			and will be completed upon hi		
		•			and on annual basis by Direct		
		proximately 21 hours			of Nursing and/or designee		
	after the incide	ent occurrea.			will the corrective action(s) be		
					monitored to ensure the defici-		
	3. An allegati	on of staff to resident			practice will not recur, i.e., who		
	abuse, that in	volved QMA #24, had			quality assurance program w		
	occurred on 7	/27/13 at 9:00 a.m. The			be put into place? * An Abus		
		ated an investigation			Prohibition and Investigation (
		id reported to the ISDH			tool will be utilized by Director		
	_	•			Nursing and/or designee week	•	
		2:55 p.m., which was			4 weeks, monthly x 2 months		
1	l almost 6 hour	s later			quarterly X1 for at least 6 mon	เนเอ	ĺ

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155377	B. WIN	IG		08/14/	2013
NAME OF F	DROVIDED OD GUDDI IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	PROVIDER OR SUPPLIEF			707 S J	ACKSON PARK DR		
SEYMOL	JR CROSSING			SEYMO	DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	W. O. VIII. W. V. V. O. G. D. D. G. W. V. V.	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE
	10:36 a.m., the CNA's did not supervisor unti	l 11:00 a.m.			* Audit tools will be submitted the CQI committee and action plans will be developed as needed if threshold of 100% is not met.		
	4. An investigation of a reportable allegation of staff to resident abuse						
		by the DHS on 8/8/13 at					
		•					
	3:20 p.m. The investigation indicated that a family member of a discharged						
	1	dent #A) had reported					
	,	he facility that were					
		are" and also were					
	_	e to the resident to the					
	_	9/12. Resident #A had					
	been discharge						
	Deen discharge	ed III 9/2012.					
	During an inter	view on 8/14/13 at					
	_	DHS indicated they					
		confirmation the					
		been reported to the					
		er agencies, so they					
		d reported this on					
	8/14/13 at 5:01	-					
		1					
	A policy, titled	"Abuse Prohibition,					
		Investigation" policy					
		, was provided by the					
	•	ctor on 8/12/13 at					
	11:04 a.m. Th	e policy indicated, but					
		I to, "It is the policy of					
		or Communities to					
	protect residen						
	l '	ical abuse, sexual					
	Reporting, and and procedure Executive Dire 11:04 a.m. Th was not limited American Seni protect residen	, was provided by the ctor on 8/12/13 at e policy indicated, but I to, "It is the policy of or Communities to ats form abuse					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 20 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		OO OO	(X3) DATE SURVEY COMPLETED
ANDILAN	155377	A. BUILDING	00	08/14/2013
	100077	B. WING	PPPPG GWY	JUI 17/2013
	PROVIDER OR SUPPLIER JR CROSSING	707 S J	ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR DUR, IN 47274	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds1. American Senior Communities will not permit residents to be subjected to abuse by anyone, including employees, other residents5. All abuse allegations/abuse must be reported to the Executive Director immediately7. The Executive Director/designee will report all unusual occurrences, which include allegations of abuse, immediately, to the Long Term Care Division of the Indiana State Department of HealthCopies of the completed investigation must also be sent to Adult Protective Services, Ombudsman, and Director of Operations" This Federal tag relates to Complaint IN00128887. 3.1-28(a)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 21 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155377	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/14/2013
	ROVIDER OR SUPPLIER JR CROSSING	707 S .	ADDRESS, CITY, STATE, ZIP CODE JACKSON PARK DR DUR, IN 47274	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F000246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F000246	F 246 REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the far with reasonable accommodat of individual needs and preferences, except when the health or safety of the individu or other residents would be endangered What correct action(s) will be accomplished those residents found to have been affected by the deficient practice? *Resident #H was n harmed by alleged deficient practice *Resident #H still currently on thickened liquids *Thickened liquids will be provided at bedside in insulat container *All staff inserviced hydrational needs on Septem 6, 2013 How will you identify residents having the potential be affected by the same defic practice and what corrective action will be taken. * Resider who reside in this facility have potential to be affected by the alleged deficient practice *	o9/06/2013 ent cility ions ual live of for live on ber other to ient lits ethe
			Director of Nursing and/or designee completed hydration assessments on all residents	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 22 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155377	B. WING		08/14/2013	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	R		JACKSON PARK DR		
SEVMOL	JR CROSSING			OUR, IN 47274		
SETWO	JK CKOSSING		SETIVIC	30K, IN 47274		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG		DATE	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	receive thickened liquids *Thickened liquids will be provided at bedside in insulate container * All staff inserviced the Director of Nursing and/or designee on hydrational need September 6, 2013 What measures will be put into plac what systemic changes you w make to ensure that the defici practice does not recur? * All inserviced by the Director of Nursing and/or designee on hydrational needs on Septeml 6, 2013 *Thickened liquids wil provided at bedside in insulate container *Activity assistants w offer hydration to all residents when passing hydration cart a designated times each day * Director of Nursing and/or designee will be responsible to ensure hydration cart is being utilized at each designated tim Director of Nursing and/or designee will complete hydrat assessments on all residents receive thickened liquids quarterly, annually and with an significant change *Licensed nurses will ensure insulated containers will be provided at bedside for residents receiving thickened liquids on all shifts *Director of Nursing and/or designee will ensure all reside are assessed for hydrational needs between each meal H	ed by son e or ill ent staff ber I be ed will tt one * ion who ent	
				will the corrective action(s) be monitored to ensure the defici practice will not recur, i.e., wh quality assurance program wi	ent at	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 23 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155377	B. WIN			08/14/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SEYMOL	JR CROSSING				ACKSON PARK DR DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	T	ID	PROVIDENCE NAME OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG	Based on obserecord review to provide fluids to preferred for 1 reviewed for ac 2 residents who hydration (Resident indicated she wand the facility anything to drimeresident indicated she wand the hallway the something to dindicated she gwas in her bediends.	rvation, interview and he facility failed to o one resident as of 2 residents dequate fluid intake of o met the criteria for ident #H). Resident #H, on 8-6-13 dicated the she did not dis she wanted as The resident was on thickened fluids did not give her ak in her bedroom. The ted if she was sitting in a staff would give her rink. The resident tot thirsty when she room.		TAG	be put into place? * An Altered Fluid Consistency CQI tool will utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months an quarterly X1 for at least 6 mon * Audit tools will be submitted the CQI committee and action plans will be developed as needed if threshold of 95% is met.	d ths	DATE
	10:10 a.m., Re any fluids in he	sident #H did not have r bedroom.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 24 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	00	COMPLETED		
	155377	B. WING		08/14/2013		
	PROVIDER OR SUPPLIER JR CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			
	Interview with Resident #H, on 8-7-13 at 2:50 p.m., indicated the staff had not given her anything to drink in her bedroom. Resident #H indicated the staff gave her something to drink when she sat in the hallway and with her medication. The resident indicated she got thirsty when she was in her bedroom and there was no set time she received fluids. The resident stated "well it is the way it is I guess". Interview with CNA #2, on 8-7-13 at 2:53 p.m., indicated fluids were passed on second shift at 2:00 p.m. and at 8:00 p.m. CNA #2 indicated there was a list of residents on the hydration cart of the type of fluids each resident received. CNA #2 indicated activity staff passed the fluids at 2:00 p.m. Interview with Activity staff #5, on 8-7-13 at 3:01 p.m., indicated she had passed fluids on two hallways and was now passing it on the third hallway. Activity staff #5 indicated she had a list of all the residents on the hydration cart with the type of fluid they received. Activity staff #5 indicated the residents who received thickened liquids a CNA stayed with the resident while they drank their					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 25 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	IULTIPLE CO	00	(X3) DATE COMPL	
THAD TEAM	or condition	155377		LDING		08/14/	
			B. WIN		ADDRESS CITY STATE ZIR CODE		
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR		
SEYMOU	JR CROSSING				OUR, IN 47274		
(X4) ID	SUMMARY S	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		staff #5 provided the					
		s on the hydration cart,					
		as listed as nectar thick					
	liquids (liquid th						
	consistency to	help prevent choking).					
	الملمسية منتاناتا	Desident #11 formiller					
		Resident #H family					
		7-13 at 3:05 p.m.,					
		esident was thirsty a					
	_	member indicated the keep fluids available in					
	,	•					
		did not anymore. The indicated he did not					
	•	ident's medication was					
		rsty, but when he came					
	_	emed thirsty a lot.					
		dicated at this time she					
		servation at this time					
	_	5 walked past Resident					
	,	and did not offer the					
	resident any flu						
	Tosident any III	AIGG.					
	Interview with	Activity staff #5, on					
		p.m., indicated yes she					
		sing the hydration cart					
		s. When queried why					
		as not offered any					
		staff #5 indicated she					
	_	sed giving fluids to					
		nd would get the					
		thing to drink at this					
	time.	aming to drink at tillo					
	unio.						
	Interview with	Activity staff #5, on					
		p.m., indicated she told					
	5 / 10 at 0.20	p.iii., iiididated dile told					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 26 of 77

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE COMPL	
		155377	A. BUILDI B. WING	ING		08/14/	2013
	PROVIDER OR SUPPLIEF	.		707 S JA	DDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR UR, IN 47274		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES		ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		ΓAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
		assigned CNA the day a nectar thick coke.					
	4:00 p.m., indicated not inform wanted someth indicated Active a coke could be and she told he could make a region #2 indicated she Resident #H a Interview with 4:30 p.m., indicated	CNA #2, on 8-7-13 at cated the Activity staff her that Resident #H ning to drink. CNA #2 ity staff #5 asked her if e made nectar thick er the dietary staff nectar thick coke. CNA ne would go get nectar thick coke now. CNA #2, on 8-7-13 at cated she gave nectar thick coke and ed it.					
	on 8-8-13 at 12 resident's diag were not limite disorder, anxie infections, Part constipation ar The physician's for Resident #lindicated the resident #lindicated #lindicat	record of Resident #H, 1:34 a.m., indicated the noses included, but d to, major depressive ety, chronic urinary tract kinson's disease, nd hypertension. s recapitulation orders H, dated August 2013, esident's diet order was ft with puree soups and r thick liquids.					
		Data Set (MDS) ated 6-17-13, for					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 27 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	COMPL		
		155377		LDING		08/14/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER				ACKSON PARK DR		
SEYMOL	JR CROSSING				UR, IN 47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG		dicated the resident		TAG			DATE
		sive assistance of					
	person to eat a						
	6-27-13, for Re	sk assessment, dated esident #H indicated as not on a fluid					
	provided by Me 8-7-13 at 6:40 water will be pa	management policy edical records, on p.m., indicated fresh assed to all residents, ly contraindicated, on					
	This federal tag number IN0012	g relates to complaint 28887.					
	3.1-3(v)(1)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 28 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155377	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/14/2013	
	PROVIDER OR SUPPLIER JR CROSSING	707 S 3	ADDRESS, CITY, STATE, ZIP CODE JACKSON PARK DR DUR, IN 47274		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F000279	F 279 DEVELOP COMPREHENSIVE CAREPLANS The facility repectfully requests paper rev IDR for tag F 279. The facility evidence for the following tags support the deficiencies shoul not have been sited. The care plan must describe the service that are to be furnished to atta or maintain the resident's high practicable physical, mental, a psychosocial well-being as required and any services tha would otherwise be required to not provided due to the reside exercise of rights including the right to refuse treatment. Wh	has s to d es sin neest and t out	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 29 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/14/2013		
	ROVIDER OR SUPPLIEI	?	STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF DEFICIENCY)	JLD BE COMPLETION DATE		
				corrective action(s) will be accomplished for those of found to have been affect the deficient practice? *F #58 was not harmed duralleged deficiency practice *Resident #58 careplant updated to reflect any positioning/comfort concurrent gerichair *Reside currently in occupational to address any comfort of the How will you identify out residents having the pote be affected by the same practice and what correct action will be taken? *All residents have the potent affected by the alleged depractice *Licensed Nurse IDT have been re-educa updating careplans to recurrent status of each respected by PT/OT to eappropriate positioning of were in place and care powere updated accordingly measures will be put into what systemic changes you make to ensure that the practice does not recure *Careplans are reviewed updated by IDT at least of admission, quarterly, and significant change to ensure that the practice does not recure the place *Licensed Nurses have been re-educated to the place *Licensed Nurses	residents reted by Resident ring re rhas been erns with ent #58 is therapy concerns rher rential to deficient tive ritial to be reficient res and red on flect the ritident by ritident		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 30 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES X1) PROVIDER/SUPPLI DF CORRECTION IDENTIFICATION NUM 155377	MBER:	(2) MULTIPLE CO . BUILDING . WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/14/2013
	ROVIDER OR SUPPLIER		707 S J	DDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR UR, IN 47274	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIE (EACH DEFICIENCY MUST BE PRECEDE REGULATORY OR LSC IDENTIFYING INF	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
	Based on observation, record rand interview, the facility failed ensure care plans were develoaddress the need for positionin in a geri chair for 1 of 34 resid whose care plans were reviews (Resident #58)	to pped to g while ents		updating careplans to reflect the current status of each resident SDC/designee on September 2013 *All residents with positioning concerns were evaluated by PT/OT to ensure appropriate positioning device were in place and care plans were updated accordingly *Non-compliance with facility policy and procedure may resuin employee education and/or disciplinary action. *DNS/designee will monitor for compliance How the correctivaction(s) will be monitored to ensure the deficient practice who trecur, i.e., what quality assurance program will be put into place? *A Careplan updat CQI tool will be utilized by Director of Nursing and/or designee weekly x 4 weeks, monthly x 2 months and quarte X1 for at least 6 months * Aud tools will be submitted to the Committee and action plans with be developed as needed if threshold of 95% is not met.	t by 6, s s ult r ve vill ing erly it CQI

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 31 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	LDING	NSTRUCTION 00	(X3) DATE COMPL 08/14/	ETED
	PROVIDER OR SUPPLIER JR CROSSING		 707 S J	DDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR UR, IN 47274	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Findings includ	e:				
	Resident #58 of a.m., Resident be leaning to he geri chair. Resident uncomfortable, using a pillow of him sit more upindicated that he work. Resident that staff has no pillow for this for During observations. Resident #58 of a.m., Resident in geri chair with his right side a his legs. Resident #58 of a.m., Resident with his right side a his legs. Resident #58 of a.m., The clinical recovers are sident was reviewed of p.m. The recovers for activition 105/19/11 with a side of the sident with a side of the clinical recovers for activition 105/19/11 with a side of the side of the clinical recovers for activition 105/19/11 with a side of the sident with the side of the clinical recovers for activition 105/19/11 with a side of the sident with the side of the sident with the side	ation and interview with on 08/07/13 at 9:12 #58 was observed up the blue foam bracing to and some pillows under dent # 58 indicated that affortable. Ford for Resident # 58 on 08/07/13 at 3:33 and indicated a plan of the es of daily living dated approach noted that of in geri chair for				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 32 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 08/14/	ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR UR, IN 47274	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
TAG	During observation 08/07/13 at #58 was observation impersonator is straighter in the foam pillow to indicate the puring interview Therapist) #6, in p.m., for current ocumentation indicated that he current PT documentation balance in positioning in compositioning in compositio	ation of Resident #58 4:13 p.m., Resident ved enjoying the Elvis show while sitting e geri chair with blue right side. w with PT (Physical on 8/12/2013 at 2:01 at therapy and history, PT #6 are only had access to umentation. PT #6 urrent Physical Therapy otes dated 07/16/13 for ey edema nening. Functional e/static - unable to ce without mod/max		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	DATE
	and rectangle t	olue wedge in the geri					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 33 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER: 155377	A. BUILDING B. WING	00	COMP	LETED 4/2013		
NAME OF PROVIDER OR SUPPLIE	R	707 S	STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274				
PREFIX TAG (EACH DEFICIE REGULATORY O chair of Resid with him for a in bed. They started to use (surveyors) int about his chai day. They als	statement of deficiencies NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) ent #58 had been used long time for positioning indicated that they them for him after we terviewed Resident #58 ir positioning the other o indicated that	ID PREFIX TAG	PROVIDER'S PLAN OF CORREGEACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
Resident's wh weeks ago an to use the ger wheelchair. The current cl reviewed, on 0 for Resident a	eelchair broke a few d Resident #58 chose chair instead of the inical plans of care were 08/14/13 at 11:00 a.m., #58, and these records a care plan for						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 34 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	, DINI DDIG 00		00	COMPLETED	
		155377	A. BUII		- ,	08/14/2	013
			B. WIN				0.0
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					JACKSON PARK DR		
SEYMOL	IR CROSSING			SEYMO	DUR, IN 47274		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	(COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DATE	
F000281	483.20(k)(3)(i)						
SS=D	SERVICES PRO	VIDED MEET					
	PROFESSIONAL	. STANDARDS					
	The services prov	vided or arranged by the					
	facility must meet	professional standards of					
	quality.						
			F00	0281	F281 SERVICES PROVIDED		09/06/2013
	Based on recor	rd review and			MEET PROFESSIONAL		
	interview the fa	acility failed to ensure			STANDARDS The services		
		a physician's order for			provided or arranged by the		
					facility must meet professional		
		glucose monitoring.			standards of quality. What		
		of 34 residents			corrective action(s) will be		
	reviewed for ph	nysician orders in a			accomplished for those reside		
	sample of 34.	(Resident #5)			found to have been affected by		
	-				the deficient practice? *Reside #5 was not harmed during alle		
	Findings includ	e:			deficiency practice *Resident	-	
		-			physician's orders were clarified		
	A record review	v was conducted for			to include complete accuchech		
					order How will you identify ot		
	-	n 8/14/13 at 9:30 a.m.,			residents having the potential		
	and indicated F				be affected by the same defici	ent	
	diagnoses inclu	uded, but were not			practice and what corrective		
	limited to, insul	in dependent diabetes			action will be taken? *All		
	mellitus, pancre	eatitis, chronic alcohol			residents have the potential to		
	abuse, and hyp				affected by the alleged deficie		
	abacc, and my				practice *Licensed Nurses and		
	Signed physicia	an orders for 9/1/12			nurse managers were inservice		
		an orders for 8/1/13			on ensuring complete accuche orders are present in the	eck	
	-	3 included, but were			Medication Administration Rec	ord	
	not limited to, t	he following			*100% audit of all accucheck		
	medications:				orders on diabetic residents w	as	
					completed by September 6, 20		
	1. "Lantus	100/ml (millimeters)			What measures will be put i		
		ct 25 units sub-Q daily			place or what systemic change		
	_	bedtime (7/5/13)"			you will make to ensure that the		
	•	• •			deficient practice does not rec	ur?	
		og 100 /ml INJ inject			*Licensed Nurses and nurse		
		per sliding scale: 151-			managers were inserviced on		
	200= 3	units; 201-250=6 units;			ensuring complete accucheck		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A PHILI PINIC 00		COMPLETED	
		155377		LDING		08/14/	2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
CEVMOL	ID CDOSSING				ACKSON PARK DR		
SEYMOUR CROSSING			SETIVIC	DUR, IN 47274			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	251-30	0=8 units; 301-350 = 12			orders are present in the	_	
	units; 3	51-400 = 14 units; >			Medication Administration Red	cord	
	400 = 1	16 units - document flow			*100% audit of all accucheck	-00	
	sheet"				orders on diabetic residents w completed by September 6, 20		
		gen Hypokit INJ Inject			*Non-compliance with facility	313	
		ng) IM as needed if BG			policy and procedure may resi	ult	
		d unresponsive to oral			in employee education and/or		
		e for DX: DM"			disciplinary action *Medical		
	giucose	E IOI DA. DIVI			Records and/or designee will		
					ensure diabetic orders are		
		order related to			appropriate and accurate on a		
	capillary blood glucose monitoring				monthly basis during end of th		
	frequency was found on physician				month change over *Director of Nursing and/or designee will a		
	orders, medication administration				all orders of new	iddit	
	records, or in t	he resident's medical			admission/readmissions to the	;	
	record. Reside	ent #5's "Capillary			facility to ensure accuracy of		
		Monitoring Tool" flow			diabetic orders *DNS/designe	е	
		erved to have the			will monitor for compliance H		
		d glucose documented			the corrective action(s) will be		
		"QID" (four times per			monitored to ensure the defici		
	1	•			practice will not recur, i.e., who quality assurance program will		
	1 .	-written at the top of			put into place? *A Pharmacy	ı be	
		of the resident's flow			Services CQI tool will be		
	sheet.				utilized by Director of Nursing		
					and/or designee weekly x 4		
	An interview w	as conducted, on			weeks, monthly x 2 months ar		
	8/13/13 at 11:5	50 a.m., with LPN #13,			quarterly X1 for at least 6 mon		
	LPN #12, and	LPN #14. Each LPN			* Audit tools will be submitted		
	indicated that t	here should be a			the CQI committee and action		
	physician's ord	ler for frequency of			plans will be developed as needed if threshold of 95% is	not	
	1	monitoring for those			met	1100	
		ving insulin and that it					
		ted on the physician's					
		onally, each LPN					
		here was no standing					
		policy regarding					
	frequency of bl	ood alucose					

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155377	A. BUI	LDING	00	COMPL 08/14/	
		199911	B. WIN			00/14/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SEYMOL	JR CROSSING			1	ACKSON PARK DR DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROUBERG DE AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	monitoring for r	residents receiving					
	insulin. Follow	ing a thorough review					
	of Resident #5'	s chart, LPN #13					
		she could not locate					
	any physician's	s order for glucose					
		where in the resident's					
	_	the admission orders.					
		ndicated that there was					
	•	ding blood glucose					
	•	to the resident's sliding					
		sked how frequently					
	•	orm capillary blood					
	_	oring for a resident who					
		n, LPN #13 indicated,					
	_	cale says AC (before					
	•	(hour of sleep), I do it					
	four times a da	y."					
	In an interview	with the Director of					
	Nursing (DON)	, on 8/13/13 at 12:05					
	p.m., she indica	ated that orders for					
	capillary blood	glucose monitoring					
	frequency shou	uld be located in					
	physician's ord	ers and that the facility					
	does not have	a standing order or					
	facility policy re	egarding frequency of					
	blood glucose i	monitoring for					
	residents recei	ving insulin.					
	On 8/13/13, at	1:45 p.m., the DON					
		ted physician's orders,					
		en capillary blood					
		oring indicating four					
	times daily.	<u>.</u>					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 37 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155377			LDING	NSTRUCTION 00	(X3) DATE COMPL 08/14/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	ratement of deficiencies CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) On 8/14/13 at 5:00		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	not have a writ	ed to physician order or performing capillary						
	procedure entite Monitoring" was on 8/13/13 at 2 indicated, but with the policy of the immediate treathypoglycemia" indicated, "Resphysician's ord capillary blood	The procedure idents who have a er to obtain routine glucose will have a er specifying the blood eters requiring						
	Process, and Findicated: "The responsible for treatment. Nur follow physician believe the ord would be detrire physician shou	directing medical ses are obligated to n's orders unless they ers are in error or nental to clientsThe ld write all orders, and make sure that they						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 38 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155377	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 08/14	LETED		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR				
SEYMOL	JR CROSSING		SEYMOUR, IN 47274					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE		
	3.1-35(g)(1)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 39 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155377				LDING	ONSTRUCTION 00	(X3) DATE : COMPL 08/14/	ETED
	ROVIDER OR SUPPLIER		P . W.	707 S J	ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR DUR, IN 47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F000309 SS=D	must provide the services to attain practicable physic psychosocial well	BEING st receive and the facility necessary care and or maintain the highest	F00	0309	F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, a psychosocial well-being, in accordance with the comprehensive assessment at plan of care. What corrective action(s) will be accomplished those residents found to have been affected by the deficient practice? *Resident #96 or #56 was not harmed during alleged deficiency practice *Resident ris currently in occupational therapy to address any comfor concerns with care plan to refl any changes for positioning *Resident #96 is currently free infection in wound. How will yidentify other residents having potential to be affected by the same deficient practice and will corrective action will be taken? *All residents have the potential be affected by the alleged deficient practice *All staff will inserviced on infection control	nd nd for 8 d #58 rt ect of ou the nat eal to	09/06/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 40 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155377	B. WING		08/14/2013
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	1
NAME OF P	PROVIDER OR SUPPLIER			ACKSON PARK DR	
	JR CROSSING			DUR, IN 47274	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	·	DATE
TAG	·			September 6, 2013 *Non-compliance with facility policy and procedure may rest in employee education and/or disciplinary action *All resident with positioning concerns were evaluated by PT/OT to ensure appropriate positioning device were in place and care plans were updated accordingly What measures will be put into place or what systemic change you will make to ensure that the deficient practice does not rece *All staff will be inserviced by Director of Nursing Services and/or designee on infection control by September 6, 2013 *Staff Development Coordinate and/or designee will perform so validations on handwashing of staffed by September 6, 2013 *Staff Development Coordinate and/or designee will perform so validations on wound dressing changes on all licensed nurses September 6, 2013 *Non-compliance with facility policy and procedure may resuling in employee education and/or designey will monitor for compliance *All residents with positioning	ult ts es s o es ne ur? or kills n all or kills s by ult
				concerns were evaluated by PT/OT to ensure appropriate	200
				positioning devices were in pla and care plans were updated accordingly How the correct	
				action(s) will be monitored to	
				ensure the deficient practice w	/ill
				not recur, i.e., what quality	
			1		1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 41 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155377	B. WIN	G		08/14/	2013
NAME OF I	PROVIDER OR SUPPLIER	\ {			ADDRESS, CITY, STATE, ZIP CODE		
CEVMOI	ID CDOCCING				ACKSON PARK DR		
	JR CROSSING			SETIVIC	OUR, IN 47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL I SC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	Based on obse and interview, address one repositioning whi (Resident #58) healing and president with work the criteria of 3 residents wound care. Findings include 1. During obse with Resident # a.m., Resident be leaning to higeri chair. Resident	ervation, record review, the facility failed to esident's need for le in a geri chair and failed to promote event infection for a rounds (Resident #96). of 3 residents who for positioning and 1 who met the criteria for le: ervation and interview #58 on 08/06/13 at 9:18 #58 was observed to is right side when up in sident #58 reports that as that way and is not		TAG	assurance program will be puinto place? *An infection control CQI tool will be utilized by the Director of Nursing and/or designee weekly x4 weeks, monthly x2 months and quartex1 for at least 6 months *A Range of Motion CQI tool will utilized by the Director of Nursiand/or designee weekly x4 weeks, monthly x2 months and quarterly x1 for at least 6 months *Audit tools will be submitted the CQI committee and action plans will be developed as needed if threshold of 95% is met.	t rol erly be sing ad aths to	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 42 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155377	A. BUI	LDING	00	COMPLET 08/14/20	
		100017	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/14/20	,10
NAME OF P	PROVIDER OR SUPPLIER	8			ACKSON PARK DR		
SEYMOL	JR CROSSING			1	DUR, IN 47274		
(X4) ID		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
		When asked about					
	using a pillow o	on his right side to help					
		oright, Resident #58					
		ne thought that might					
		t #58 also indicated					
	that staff has n	ot offered to try a					
	pillow for this for	•					
	During observa	ation and interview with					
	Resident #58 c	on 08/07/13 at 9:12					
	a.m., Resident	#58 was observed up					
	in geri chair wi	th blue foam bracing to					
	his right side a	nd some pillows under					
	his legs. Resid	dent # 58 indicated that					
	he is more con	nfortable.					
	The clinical red	cord for Resident # 58					
	was reviewed	on 08/07/13 at 3:33					
	p.m. The reco	rd indicated a plan of					
	care for activiti	es of daily living dated					
	05/19/11 with a	approach noted that					
	resident sits up	in geri chair for					
	positioning at t	his time.					
	During observa	ation of Resident #58					
	on 08/07/13 at	4:13 p.m., Resident					
	#58 was obser	ved sitting straighter in					
	geri chair with	blue foam pillow to					
	right side.						
	During intervie	w, on 08/13/13 at					
	· ·	IA's #9 and #10,					
		he blue foam wedge					
	_	blue wedge in geri chair 8 had been used with					
	UI RESIDENT #5	o nau been useu Willi					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 43 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPI	LE CON	ISTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	
		155377	B. WING			08/14/	2013
NAME OF F	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE		
05)/1401	ID 00000N0				CKSON PARK DR		
SEYMOU	JR CROSSING		SE	YMOU	JR, IN 47274		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL	PREFI TAC		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		time for positioning in	TAC		DETERMINETY.		DATE
		time for positioning in					
	for him after w	ey started to use them					
		esident #58 about his					
		ng the other day. They					
		that Resident's					
		oke a few weeks ago					
		# 58 chose to use the					
		ead of the wheelchair.					
		ad of the important					
	The current cli	nical plans of care were					
		08/14/13 at 11;00 a.m.,					
	· ·	458 and these records					
	did not include	a care plan for					
	positioning.	•					
	2. Resident #	96's record was					
	reviewed on 8	/7/13 at 4:10 p.m. The					
	record indicate	ed Resident #96's					
	diagnoses incl	uded, but were not					
	limited to: high	blood pressure, history					
		cers on feet, peripheral					
		ciency, depression, and					
	•	th weakness on one					
	side.						
		e plan indicated,					
		t Date: 3/11/13:					
		: Res[ident] has					
	· ·	ntegrity: ulcers to R					
		g of lower extremity as					
		to wear protective					
	shoe/sock/boot to right foot. Will						
		ssings to be changed					
	due to sollage	. Educated on risk for					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 44 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155377	B. WIN	G		08/14/	2013
	ROVIDER OR SUPPLIER	2		707 S J	ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	T	ID	PROVIDENCE NAME OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
IAU	infection with de Goal: (target da will show no six Approaches: (rupdate/start da educate when changed due to reason for dress A review of "Sk ASC Non-press Evaluation Repand provided be Nursing (DON) p.m., indicated right inner foot 2/15/13. The wax W 2.4xm X D was indicated to color and have drainage." Interdisciplinar progress notes p.m., were provided: "Relacerations to findicated: "Relac	Iressings/drainage. ate 10/22/13); Areas gns of infection; most recent ate: 8/1/13) "continue to dressings need o drainage or soilage asing change". Kin Integrity Events - sure Wound Skin bort", dated 3/15/13, by the Director of o on 8/14/13 at 12:40 an existing area to the originally noted on round measured L 4cm o 0.3cm. The wound to be "yellow, red" in a "moderate purulent by team (IDT) meeting s, dated 4/3/13 at 3:10 wided by the DON on o p.m. The IDT notes sident has wound from RT foot that shows rement."		IAU			DATE
	7/6/13 at 10:29 the DON on 8/ indicated Resid	rogress notes dated o a.m., and provided by 14/13 at 4:10 p.m., dent #96's diagnosis m lacerated areas to					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 45 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	OO	COMPL		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155377	A. BUI	LDING	00	COMPL 08/14/	
		100011	B. WIN			00/14/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SEYMOL	JR CROSSING				ACKSON PARK DR DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		right foot. Mod[erate]					
	•	w drainage noted. No					
		ound bed yellow.					
		ned honey continues.					
		ppt with wound care on					
		ibuting DX include					
		iency, HTN, Hx of					
		Currently consumes					
	_	% of meals. CNA eets and CP updated.					
	Will reassess in						
		I (Wound Nurse), MDS					
		Set Coordinator),					
	,	nt Director of Nursing					
	Services."	zester e. rtareg					
	IDT team meet	ing progress notes					
		: 2:53 p.m., and					
	provided by the	DON on 8/14/13 at					
	4:10 p.m., indic	cated, "Resident had					
	stasis areas on	right foot that has					
	become one we	ound. Large amount of					
	mucopurulent o	drainage noted. Foul					
	odor noted. W	ound bed lime green					
	with white sloug	gh. Area shows no					
	improvement.	Treatment of					
	-	tinues QOD (every					
	other day)".						
	Resident #96's	•					
	•	/13 to discontinue					
	-	nent to right foot. The					
	•	ated, "Apply tender					
		foot. Change QD.					
	Secure with ku	rlex QD". The care					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 46 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155377	B. WIN	IG		08/14/2013
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	
05,4401	ID 00000N0				ACKSON PARK DR	
SEYMOU	JR CROSSING			SEYMO	UR, IN 47274	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	BEIGHNOT	DATE
	l •	the problem to be that				
		not improving and had nage. Goals included				
	improvement o	_				
	<u> </u>	nage. Interventions				
	included the ne	_				
	included the ne	w treatment.				
	A review of "Sk	kin Integrity Events -				
		ssure Wound Skin				
		oort" dated 8/2/13, and				
		e DON 8/14/13 at 4:10				
	'	the right foot wound				
	l •	were: L 8.6cm X W				
	13.0cm X D 0.2	2cm. Wound color was				
		"lime green with white				
		d drainage was				
	. •	"large mucopurulent"				
	and odor was "					
	A review of "Sk	kin Integrity Events -				
	-ASC Non-Pres	ssure Wound Skin				
	Evaluation Rep	oort", dated 8/9/13 and				
		e DON 8/14/13 at 4:10				
	p.m., indicated	the right foot wound				
	measurements	were: L 8.4cm X W				
	12.8cm X D 0.2	2cm. Wound color was				
	indicated to be	"pink in areas with				
	lime green area	as". Wound drainage				
	was indicated t	o be "light green large				
	amt" and odor	was "Moderate".				
	IDT meeting pr	ogress notes dated				
	•	o.m., and provided by				
		14/13 at 4:10 p.m.,				
		sident has stasis areas				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 47 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155377	B. WIN	IG		08/14/	2013
NAME OF P	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KO VIDEK OK SOTTEIEN				ACKSON PARK DR		
SEYMOL	JR CROSSING			SEYMO	OUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	at has become one					
	wound. Large a						
	•	drainage noted. Foul					
		ound bed lime green					
	•	throughout. Area					
		ment. Will continue					
	current treatme	ent of tender wet."					
	An intensions or	nd observation of					
		th LPN #13 was					
		3/8/13 at 1:21 p.m.					
		ated she frequently					
	l ·	d care and dressing					
	•	esident #96 and is					
		s plan of care. LPN					
		hat Resident #96's					
	•	d(s) were present on					
		started as "a little cut"					
		is right foot being run					
	•	elchair. LPN #13 was					
		ral minutes prior to					
		lies and entering					
		room. She did not					
	wash her hand						
	sanitizing gel.						
	observed placi	•					
	1	sident #96's bedside					
	· ·	ning multiple items,					
		and drink, down the					
	1	ble to make room.					
		placed plastic bags on					
		clean cloth pad (chux)					
		neath Resident #96's					
		n his wheelchair. LPN					
	#13 then donne	ed gloves and removed					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 48 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

			2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155377	B. WIN	G		08/14/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ACKSON PARK DR		
SEYMOL	JR CROSSING			SEYMO	DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPL		TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		dressing. LPN #13					
	_	oves and threw them					
	-	bags on the floor.					
		ooured normal saline					
	into a plastic di	•					
	indicated to Re	sident #96 that she					
		ean his right foot					
		donned clean gloves.					
	LPN #13 was o	bserved opening					
	packs of 4x4 g	auze to clean wound					
	using appropria	ate technique. Resident					
	#96's right foot	wound was observed					
	to cover 75% o	f the anterior portion of					
	his foot, have a	a yellow wound bed, a					
	large amount o	f white slough, and					
	was red and in	flamed around the					
	borders. After	cleansing the wound,					
	LPN discarded	her gloves and					
	donned clean g	gloves. She was					
	observed to op	en 2					
	individually-wra	apped dressing					
	packages and	place the dressings on					
	the wound. Sh	e then wrapped the					
	right foot with o	gauze kurlex, taped the					
		dated and initialed it.					
	_	removed her gloves					
		form any hand hygiene					
	•	new gloves to provide					
	·	Resident #96's right					
	lower extremity						
	An interview wi	th the DON on 8/14/13					
		e DON indicated her					
	' '	or the staff, regarding					
	•	were: "Before and					
	I						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 49 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE (COMPL		
11112 12111	or confidence.	155377	1	LDING		08/14/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER				ACKSON PARK DR		
SEYMOL	JR CROSSING			SEYMO	DUR, IN 47274		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		dentanything that is		TAG	DEFICIENCE!		DATE
		ed or unclean" When					
	asked specifica						
	•	indicated, "Twenty					
	seconds."	•					
	_	ervation, on 8/6/13 at					
	•	ident #96 was sitting					
	•	hair watching an Ivis impersonator in the					
	•	om. The Kurlex					
	_	ntact and there was no					
	_	ressing on the foot. The					
	foot and bare h	neel were resting on the					
	floor. The dres	ssing was dirty and					
	slightly frayed	around edges.					
	During an obse	ervation, on 8/8/13 at					
	_	sident #96 was eating					
	•	ole and seated in his					
	wheelchair. Hi	s right foot rested on					
	the floor with th	ne gauze dressing					
		neel and toes exposed.					
		as dirty and slightly					
	frayed around	edges.					
	During an obse	ervation, on 8/14/13 at					
	_	sident #96 was sitting					
	•	ing room at a table					
		ntact on his right foot					
	and calf. The f	oot and heel rested on					
		ressing was light					
		round edges, and					
	slightly frayed.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 50 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155377	B. WIN	G		08/14/	2013
NAME OF F	PROVIDER OR SUPPLIEF	8			DDRESS, CITY, STATE, ZIP CODE		
0=\0.40\					ACKSON PARK DR		
SEYMOU	JR CROSSING			SEYMO	UR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		d Hygiene CNA Skills					
		cy/procedure with					
		03/2012, provided by					
		8/09/13 at 1:34 p.m.,					
		ollowing was noted					
	· •	re step #6: Use friction					
	for at least 20	seconds.					
	A	a attituda III kanainan Dali'aa					
		acility's "Nursing Policy					
& Procedure for Dressing Change							
(Incision or Wound) " was provided							
by the DON on 8/12/13 at 11:00 a.m.							
	· ·	steps indicated the					
	_	/erify resident and					
	1	rs; 2. Provide privacy					
		ocedure; 3. Place a					
		e next to the bed or a					
		stic bag at the foot of					
	,	a chair) to dispose of					
	l ·	ctious material during					
	l ·	Wash hands; 5. Set up					
		field to ensure easy					
		olies during procedure;					
		es; 7. Remove old					
		residents and put					
	directly in trash	•					
		s and discard; 9.					
		hygiene; 10. Put on					
	_	iate wound care					
		nysician order; 12.					
	Wound care re	•					
		debris or drainage from					
	. ,	Cleanse from the					
		d outward; c) Cleanse					
	in one direction	n; d) Use a separate					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 51 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155377	A. BUII B. WIN	LDING	00 	COMPLETED 08/14/2013		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE	
	stroke; e) If dra Measure wound Remove gloves Perform hand h gloves; 16. App	reach cleansing in present; f) d as needed; 13. s and discard; 14. hygiene; 15. Put on oly new dressing e physician orders"						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 52 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155377	A. BUILDING B. WING			COMPLETED 08/14/2013	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		707 S JACKSON PARK DR				
	R CROSSING		_		OUR, IN 47274		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
F000371 SS=E	The facility must - (1) Procure food f considered satisfa local authorities; a	E/SERVE - SANITARY from sources approved or actory by Federal, State or and	F00	0371	F 371 FOOD PROCEDURE, STORE/PREPARE/SERVE-S/TARY The facility must procure food from sources approved or considered satisfactory by Federal, State or local authority and store, prepare, distribute a serve food under sanitary conditions. What corrective action(s) will be accomplished those residents found to have been affected by the alleged deficient practice? *Resident # and #57 were not harmed by the alleged deficient practice? *Staff Development Coordinator and designee will complete handwashing skills validations all staff by September 6, 2013 *Director of Nursing Services and/or designee will inservice staff on infection control by September 6, 2013 *Managers will be assigned to dining room area for observation during dim services How will you identification to the residents having the potential to be affected by the same deficient practice and whe corrective action will be taken deficient practice? *Staff Development Coordinator and designee will complete	eer ies, and for 887 he on all sing fy	09/06/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 53 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155377		A. BUILDING O O O O O O O O O O O O O		COMPLETED 08/14/2013				
		155511	B. WING		00/14/2013			
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE				
SEYMOL	JR CROSSING		707 S JACKSON PARK DR SEYMOUR, IN 47274					
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION			
TAG	REGULATORT OR	LSC IDENTIFYING INFORMATION)	TAG	handwashing skills validation	5.112			
				all staff by September 6, 201				
				*Director of Nursing Services				
				and/or designee will inservice	e all			
				staff on infection control by September 6, 2013 *Manage	rs			
				will be assigned to dining roo				
				area for observation during d	ining			
				services to ensure appropriat				
				handwashing and food is har in a sanitary manner What	iui c u			
				measures will be put into place	ce or			
				what systemic changes you v	vill			
				make to ensure that the defic				
				practice does not recur? *Sta Development Coordinator an				
				designee will complete	u/oi			
				handwashing skills validation				
				all staff by September 6, 201				
				*Director of Nursing Services and/or designee will inservice				
				staff on infection control by	z ali			
				September 6, 2013 *Manage	rs			
				will be assigned to dining roo				
				area for observation during d	•			
				services to ensure appropriate handwashing and food is har				
				in a sanitary manner				
				*Non-compliance with facility				
				policy and procedure may res				
				in employee education and/o disciplinary action *Director o				
				Nursing Services will be				
				responsible for compliance				
				the corrective action(s) will be				
				monitored to ensure the defice practice will not recur, i.e., where the defice practice will not recurs the defice practice will not recur				
				quality assurance program w				
				put into place? *A Meal				
				Observation CQI tool will be				
				utilized by Director of Nursing and/or designee weekly x 4				
				and/or designee weekly X 4				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 54 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	00	(X3) DATE SURVEY COMPLETED		
	155377	B. WING		08/14/2013		
	ROVIDER OR SUPPLIER JR CROSSING SUMMARY STATEMENT OF DEFICIENCIES	707 S J	ADDRESS, CITY, STATE, ZIP CODE JACKSON PARK DR DUR, IN 47274 PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE		
	Based on observation, record review, and interview, the facility failed to serve food under sanitary conditions.		weeks, monthly x 2 months an quarterly X1 for at least 6 mon * Audit tools will be submitted the CQI committee and action plans will be developed as needed if threshold of 95% is met	nths to		
	This affected 2 of 26 residents observed for serving food under sanitary conditions, during 1 of 2 dining observations in 2 of 2 dining rooms. (Residents #87 and #57)					
	Findings include:					
	During a dining observation on 8/5/13 at 11:10 a.m., the beverage counter in the main dining room was observed to have 3 partially filled, dirty coffee cups, a pool of spilled brown liquid, an upright disposable coffee lid partially bent and stained with a brown substance, and a torn sugar packet paper.					
	During a dining observation on 8/5/13 at 11:20 a.m., the Assistant Director of Nursing Services (ADON) was observed cleaning off trash and used coffee cups from the beverage counter in the main dining room. She was observed to not wash her hands or use hand sanitizer prior to picking					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 55 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPI	
		155377	B. WIN	G		08/14	/2013
NAME OF P	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
o=\#.40\					ACKSON PARK DR		
SEYMOU	JR CROSSING			SEYMO	OUR, IN 47274		
(X4) ID	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	fee cup and a clean lid					
		of her hand touching					
		e lid. She was then					
	· ·	ensing coffee, placing					
	the lid on the c	offee, walking down					
	the hall, and se	erving to coffee to					
	Resident #87.						
	An interview w	ith the Director of					
	Nursing (DON)) was conducted, on					
	8/14/13 at 7:30	p.m. The DON was					
	asked what he	r expectations for the					
	staff were rega	arding hand washing.					
	She indicated,	"Before and after each					
	residentanytl	hing that is physically					
	soiled or uncle	an" When asked					
	specifically abo	out the hand washing					
		e indicated, "Twenty					
	seconds."	,					
	During the lund	ch observation, on					
	1	:05 a.m., CNA #23 was					
		ke covers off drink					
	dlasses on a re	esident's lunch tray in					
	_	n and then proceeded					
		drink glasses to set on					
		p of the drinking					
		#10 was observed to					
	_	nt's sandwich bun with					
	her bare hands						
	inci bare nanus	J.					
	During the lung	ch observation on,					
	_	:24 p.m., Activity					
		as observed cutting up					
		th her bare hands for					
	a Sanuwich Wil	ii iiei baie lialius iui					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 56 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
MOLLAN	OI CORRECTION	155377		LDING	00	08/14/	
		100077	B. WIN		PRESIDENCE CONTROL OF CORP.	00/14/	2010
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR		
SEYMOU	IR CROSSING				DUR, IN 47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	Resident #57.	LSC IDENTIFYING INFORMATION)		TAG	BHICHACL		DATE
	Resident #37.						
	Review of Han	d Hygiene CNA Skills					
		cy/procedure with					
		03/2012, provided by					
	the DHS on 08	/09/13 at 1:34 p.m.,					
		ollowing was noted					
	-	re step #6: Use friction					
	for at least 20 s	seconds.					
	0.4.04/3/41						
	3.1-21(i)(1)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 57 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155377	B. WING		08/14/2013		
			_	EET ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER			'S JACKSON PARK DR			
CEVMOL	JR CROSSING						
SETIMOL	IR CRUSSING		SE	YMOUR, IN 47274			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFI		COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		DATE		
F000441	483.65						
SS=E	INFECTION CON	ITROL, PREVENT					
	SPREAD, LINEN	S					
	The facility must e	establish and maintain an					
		Program designed to					
		anitary and comfortable					
		to help prevent the					
	•	transmission of disease					
	and infection.						
	(a) Infaatis - 0 - 1	ral Dragram					
	(a) Infection Cont	roi Program establish an Infection					
	Control Program						
		controls, and prevents					
	infections in the fa	•					
		procedures, such as					
	· '	pe applied to an individual					
	resident; and	oo appiioa to aii iiiaiviaaai					
		ecord of incidents and					
	· '	related to infections.					
	(b) Preventing Sp	read of Infection					
	(1) When the Infe	ction Control Program					
		resident needs isolation to					
		id of infection, the facility					
	must isolate the r						
	. , ,	ust prohibit employees with					
		disease or infected skin					
		ct contact with residents or					
	•	t contact will transmit the					
	disease.						
		ust require staff to wash					
		each direct resident contact ashing is indicated by					
	accepted profess	,					
	accepted profess	ionai practice.					
	(c) Linens						
		andle, store, process and					
		o as to prevent the spread					
	of infection.	- r					
			F000441	F441 INFECTION CONTROL	09/06/2013		
			1 200111	PREVENT SPREAD, LINENS	,		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 58 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155377		A. BUILDING B. WING	08/14/2013					
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
	JR CROSSING		707 S JACKSON PARK DR SEYMOUR, IN 47274					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help preventhe development and transmission of disease and infection. What corrective action(s) will be accomplished those residents found to have been affected by the deficient practice? *Residents #96 and were not harmed by alleged deficient practice and are receiving care following infectic control procedures *Director on Nursing Services and/or design will inservice all staff on infectic control, including washing shouch chairs and handling dirty lines. September 6, 2013 *Director on Nursing Services and/or design will inservice all licensed nurse on wound dressing changes be September 6, 2013 *All Purell hand sanitizer dispenser mour on walls have been replaced. How will you identify other residents having the potential be affected by the same deficiting practice and what corrective action will be taken? *Resident residing in the facility have the potential to be affected by the alleged deficient practice. *Director of Nursing Services and/or designee will inservice staff on infection control, including shower chairs and handling dirty lines, by Septem 6, 2013 *Director of Nursing Services and/or designee will inservice staff on infection control, including dirty lines, by Septem 6, 2013 *Director of Nursing Services and/or designee will inservice staff on infection control, including dirty lines, by Septem 6, 2013 *Director of Nursing Services and/or designee will inservice staff on infection control, including dirty lines, by Septem 6, 2013 *Director of Nursing Services and/or designee will inservice staff on infection control, including dirty lines, by Septem 6, 2013 *Director of Nursing Services and/or designee will inservice staff on infection control, including dirty lines, by Septem 6, 2013 *Director of Nursing Services and/or designee will inservice staff on infection control designee will inservice staff on infection control designee will inservice staff on	for #58 on finee ion iwer , by of inee es y inted to ent ts e all ding			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 59 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING	00	COMPLETED			
		155377	B. WING		08/14/2013			
	ROVIDER OR SUPPLIE JR CROSSING	R	STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				inservice all licensed nurses of wound dressing changes by September 6, 2013 *Staff Development Coordinator and designee will complete skills validations on hand washing validations on hand washing validations on hand washing validations on hand washing validations on walls have been replaced. What measures will put into place or what system changes will you make to ensighe that the deficient practice doe not recur? *Director of Nursing Services and/or designee will inservice all staff on infection control, including washing shour chairs and handling dirty lines september 6, 2013 *Director Nursing Services and/or designee will inservice all licensed nursion wound dressing changes to September 6, 2013 *Staff Development Coordinator and designee will complete skills validations on hand washing validations on hand washing validations on hand washing validations on walls have been replaced *Non-compliance wifacility policy and procedure in result in employee education and/or disciplinary action *Director of Nursing Services and/or designee will monitor frompliance How the correction and/or designee will monitor frompliance How the correction and/or designee will monitor frompliance How the correction to the deficient practice value of the deficient practice valu	d/or with 3 *All er I be ic ure s g ower s, by of gnee es oy d/or with 3 *All er th hay or ve vill			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 60 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION 00	î ´	E SURVEY PLETED	
		155377	A. BUILDING B. WING		08/1	4/2013
	ROVIDER OR SUPPLIER		707	ET ADDRESS, CITY, STATE, ZIP CO S JACKSON PARK DR MOUR, IN 47274	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
TAG	Based on obserecord review, ensure their infrelated to hand gloves, and wo followed for 4 cobservations. (Residents #96 Findings included 1. Resident #9	rvation, interview, and the facility failed to ection control policies hygiene, use of und care were of 15 direct care This affected and 58)	TAG	Director of Nursing and designee weekly x 4 we monthly x 2 months and X1 for at least 6 months tools will be submitted toommittee and action p be developed as needed threshold of 95% is not	/or eeks, d quarterly s * Audit to the CQI lans will d if	DATE
	record indicated diagnoses including the diagnoses inc	d Resident #96's uded, but were not blood pressure, history ers on feet, peripheral iency, depression, and n weakness on one in Integrity Events - sure Wound Skin				
	provided by the	ort" dated 3/15/13 and Director of Nursing /13 at 12:40 p.m.,				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 61 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	OO	(X3) DATE COMPL		
ANDILAN	or conduction	155377		LDING	00	08/14/	
		100077	B. WIN		PRESIDENCE CONTROL OF CORP.	00/14/	2010
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR		
SEYMOU	JR CROSSING				DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DLI ICILICI I		DATE
		kisting area to the right nally noted on 2/15/13.					
		easured L4cm x					
		3cm. The wound was					
		" yellow, red " in color					
	and have "mod	•					
	drainage."	icrate partient					
	araniago.						
	Interdisciplinar	y team (IDT) meeting					
		s, dated 4/3/13 at 3:10					
	1	ided by the DON					
	8/14/13 at 4:10	•					
		wound from lacerations					
	to RT foot that	shows minimal					
	improvement."						
		rogress notes, dated					
		a.m., and provided by					
		14/13 at 4:10 p.m.,					
		dent #96's diagnosis "					
		n lacerated areas to n right foot. Mod					
		ow drainage noted. No					
	1	ound bed yellow.					
		ned honey continues.					
		ppt with wound care on					
		buting DX include					
		eiency, HTN, Hex of					
		Currently consumes					
		% of meals. CNA					
	_	eets and CP updated.					
	Will reassess in	•					
	IDT toom mass	ling progress rates					
		ting progress notes t 2:53 p.m., and					
	ualeu 0/2/13 a	ι 2.55 μ.π., anu					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 62 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155377		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI 08/14	LETED	
	PROVIDER OR SUPPLIER		B. WIIV	STREET A	ACKSON PARK DR DUR, IN 47274	<u> </u>	
	SUMMARY S' (EACH DEFICIENT REGULATORY OR Provided by the 4:10 p.m., indicts stasis areas or become one with white slour improvement. The medihoney correctly supdated on 8/6 previous treating plan indicated, active to R food with kurlex QD indicated the provious was not increased drain improvement of decreased drain included the new state of the polymer of the DON on 8/6 indicated, "Resident Resident Resid	ratement of deficiencies CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) E DON on 8/14/13 at cated, "Resident had a right foot that has ound. Large amount of drainage noted. Foul ound bed lime green gh. Area shows no Treatment of attinues QOD". care plan was /13, to discontinue nent to right foot. Care "Apply tender wet a. Change QD. Secure ". The care plan roblem to be that the a improving and had hage. Goals included of the area and nage. Interventions	B. WIN	STREET A	ACKSON PARK DR	I E	(X5) COMPLETION DATE
	one wound. La mucopurulent o odor noted. Wo with pink areas shows improve						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 63 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155377			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL 08/14/	ETED	
		155377	B. WIN			06/14/	2013
	PROVIDER OR SUPPLIER			707 S J	ACKSON PARK DR		
SETIVIOL	JR CROSSING			SETIVIO	OUR, IN 47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
1710		nd observation of	+	1710	·		DATE
		th LPN #13 was					
		3/8/13 at 1:21 p.m					
		ated she frequently					
		d care and dressing					
	•	esident #96 and is					
	_	s plan of care. LPN #13					
		Resident #96's right					
		were present on					
	` '	started as "a little cut"					
	as a result of his right foot being run						
	over by a wheelchair. LPN #13 was observed several minutes prior to						
		lies and entering					
		room. She did not					
	wash her hand	s or use hand					
	sanitizing gel.	LPN #13 was					
	observed placi	ng wound care					
	supplies on Re	sident #96 ' s bedside					
	table after push	ning multiple items,					
	including food	and drink, down the					
	length of the ta	ble to make room. LPN					
	•	d plastic bags on the					
		an cloth pad (chux) on					
		th Resident #96's foot					
		wheelchair. LPN #13					
	_	oves and removed					
		dressing. LPN #13					
	_	oves and threw them					
	· ·	bags on the floor.					
		ooured normal saline					
	into a plastic di	<u> </u>					
		sident #96 that she					
		ean his right foot					
	wound as she	donned clean gloves.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 64 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	COMPL		
AND PLAN	OF CORRECTION	155377	A. BUI	LDING	00	08/14/	
		100011	B. WIN			00/14/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SEYMOU	JR CROSSING				ACKSON PARK DR DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		bserved opening					
		auze to clean wound					
		ate technique. Resident					
	_	wound was observed					
		of the anterior portion of					
		a yellow wound bed, a					
	_	of white slough, and					
		flamed around the					
		cleansing the wound,					
		her gloves and					
		gloves. She was					
	observed to op						
	individually-wra						
	. •	place the dressings on					
		e then wrapped the					
		gauze kurlex, taped the					
	_	dated and initialed it.					
		removed her gloves					
	•	form any hand hygiene					
	·	g new gloves to provide					
		Resident #96's right					
	lower extremity	<i>'</i> .					
		acility's "Nursing Policy					
		r Dressing Change					
	,	und) " was provided					
		8/12/13 at 11:00 a.m.					
	•	steps indicated the					
	_	erify resident and					
		rs; 2. Provide privacy					
		ocedure; 3. Place a					
	•	e next to the bed or a					
		stic bag at the foot of					
	,	a chair) to dispose of					
	potentially infe	ctious material during					
			-				-

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 65 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155377	B. WIN	G		08/14/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
05)4401					ACKSON PARK DR		
SEYMOU	JR CROSSING			SEYMO	DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		Vash hands; 5. Set up					
		field to ensure easy					
		lies during procedure;					
	_	s; 7. Remove old					
	_	residents and put					
	directly in trash	•					
	_	s and discard; 9.					
		nygiene; 10. Put on					
	_	ate wound care					
		nysician order; 12.					
	Wound care re	•					
		debris or drainage from					
	. ,	Cleanse from the					
		d outward; c) Cleanse					
		n; d) Use a separate					
	_	r each cleansing					
	,	in presentf) Measure					
		led; 13. Remove					
	_	card; 14. Perform hand					
		ut on gloves; 16. Apply					
	_	ccording to the					
	physician orde	rs"					
		d Hygiene CNA Skills					
	-	cy/procedure with					
		03/2012, provided by					
	the DHS on 08	/09/13 at 1:34 PM,					
		ollowing was noted					
	under procedu	re step #6: Use friction					
	for at least 20 s	seconds.					
	An interview w	th the DON was					
	conducted on 8	3/14/13 at 7:30 p.m.					
	The DON was	asked what her					
	expectations fo	or the staff are					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 66 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	
		155377	B. WING	·		08/14/	2013
NAME OF I	PROVIDER OR SUPPLIEF		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	KOVIDEK OK SUFFLIEF			707 S J	ACKSON PARK DR		
SEYMOL	JR CROSSING			SEYMO	OUR, IN 47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		d washing. She					
	· ·	fore and after each					
	resident(pause) anything that is physically soiled or unclean						
	` '	en asked specifically					
		edure, she indicated,					
	"Twenty secon	ds."					
	,						
	_	ndom, continuous 18/14/13, between					
		•					
		1 12:53 p.m., QMA #23					
		walking down the main					
		g and wiping her nose					
		She then walked into					
		g room and was					
		oving a dirty coffee cup					
	_	able and placing it on a					
	counter. QMA						
		alk across the dining					
		ent #58, who was being					
	_	tivities Assistant #19.					
	•	ed up a paper towel					
		#58's table with her					
		d wiped his mouth and					
	•	s observed to be					
		er of clear-cream					
	colored substa	nce.					
	_	following random					
		he "Purell" hand					
		nsers were observed to					
	be empty on A	-hall of the facility:					
	On 8/5/13 at 3	·31 nm the					
		dispenser between					
	wan-mounted (alaponaci between					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 67 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155377		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPL 08/14/	LETED					
	NAME OF PROVIDER OR SUPPLIER SEYMOUR CROSSING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274						
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETION DATE					
	On 8/8/13 at 9 wall-mounted rooms 921 ar On 8/8/13 at wall-mounted "Spa "room empty. During observed 08/08/13 at 1 unidentified a carry uncover	ide was observed to red dining room linens er uniform with her bare								

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 68 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUILIDING	00	COMPLETED
		155377	A. BUILDING		08/14/2013
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R			
OEVMOL	ID ODGGGING			JACKSON PARK DR	
SEYMOU	JR CROSSING		SEYMO	DUR, IN 47274	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
TAG F000465 SS=D	483.70(h) SAFE/FUNCTIO TABLE ENVIRO The facility must sanitary, and cor residents, staff a Based on obse facility failed to environment was oiled linen was room, handwa accessible, and not sanitized at This affected (Resident #3) rooms. Findings included the same of t	NAL/SANITARY/COMFOR N provide a safe, functional, mfortable environment for and the public. ervation, interview, the persure the vas sanitary in that as left in a resident's shing sinks were not ad shower chairs were according to directions. If of 1 resident and 1 of 3 shower decided: at 9:10 a.m., room poserved to have balled st linens on the floor group bedside table. A faint was observed. Resident esent in her room. a:20 a.m., Resident #3 sitting in her wheelchair A. The same balled st linens remained on a same location. a:30 a.m., following rvation of A-hall, the	F000465	F465 SAFE/FUNCTIONAL/SANITA COMFORTABLE ENVIRONMENT The facility in provide a safe, functional, sanitary, and comfortable environment for residents, star and the public. What corrective action(s) will be accomplished those residents found to have been affected by the deficient practice? *Resident #3 was not harmed by alleged deficient practice *Dirty laundry was removed from room of resident #3 *Soiled utility rooms were rearranged to ensure the sink was free of objects in path *Director of Nursing Services and/or designee will inservice staff on infection control, inclusivashing shower chairs and handling dirty lines, by Septem 6, 2013 How will you identify other residents having the potential to be affected by the same deficient practice and w corrective action will be taken' *Residents residing in the facilitative the potential to be affected by the alleged deficient practice. *Soiled utility rooms were rearranged to ensure the sink was free of objects in path *Director of Nursing Services.	DATE 09/06/2013 RY/ hust ff ve for ot all ding hber hat ? lity ed ce
		ere observed balled up		and/or designee will inservice	all

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 69 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLETED	
		155377	B. WIN			08/14/2	013
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			ACKSON PARK DR		
SEVMOL	JR CROSSING				DUR, IN 47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG			DATE
	•	dent #3's sliding			staff on infection control, include	ding	
	bedside table.				washing shower chairs and handling dirty lines, by Septem	phor	
					6, 2013 *Resident #3 encourage		
	On 8/7/13 at 9:35 a.m., the same				to call for assistance when		
	linens were ob	served to be in an			changing clothes to ensure the	ey	
	open plastic ba	ag on the floor under			are not left in room What	·	
		sliding bedside table.			measures will be put into place		
		sharing sociolae table.			what systemic changes will yo		
	2 During the	anvironmental tour on			make to ensure that the deficie		
	08/09/13 at 9:0	environmental tour on			practice does not recur? *Direct	ctor	
					of Nursing Services and/or designee will inservice all staff	on	
		7 and Administrator,			infection control, including		
		sinks located in the			washing shower chairs and		
		y services room and			handling dirty lines, by Septem	nber	
	900 short hall I	aundry services room			6, 2013 *Non-compliance with		
	were blocked b	by large trash cans.			facility policy and procedure m	ay	
					result in employee education		
	During an ir	nterview with CNA #8			and/or disciplinary action		
	on 08/09/13 at	9:05 a.m., when asked			*Director of Nursing Services and/or designee will monitor for	\r	
	about facility p	rocedure for cleaning			compliance *Director of Nursin		
	shower chairs	between resident use,			Services and/or designee will of		
		ted that they clean with			rounds each shift to ensure		
		en wipe dry and then			laundry is picked up and show		
		e for next resident. She			chairs are cleaned according t		
	l '	that she was unaware			manufacturer instructions Ho	w	
					the corrective action(s) will be monitored to ensure the deficient	ont	
	,	requirements with			practice will not recur, i.e., wha		
	sanitizer before	e next use.			quality assurance program will		
		5			put into place? *An infection		
	_	view with the DHS on			control CQI tool will be utilized	by	
		:40 a.m., she indicated			Director of Nursing and/or		
	the procedure for wiping down shower chair equipment is to spray the shower chair, wait 3 minutes, then dry				designee weekly x 4 weeks,		
					monthly x 2 months and quarte		
					X1 for at least 6 months * Audi	II	
		indicated that CNA #8			tools will be submitted to the C committee and action plans wi		
		iced at this time.			be developed as needed if	"	
	g 3	- -			threshold of 95% is not met		

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED 08/14/2013	
		155377	B. WING		06/14/2013	
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
SEYMOL	JR CROSSING			OUR, IN 47274		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	DROWIDEDIC DI AN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		terial Safety data Sheet				
		e Sheet for TB Quat				
		3/09/13 at 2:00 PM er directions for use: It				
		of Federal Law to use				
		a manner inconsistent				
	-	g. Using approved				
	AOAC test me	ethods, in the presence				
		erum and a 3 minute				
		unless otherwise noted,				
	-	lls the following				
	inanimate surf	hard non-porous				
	manimate sun	aces.				
	3.1-19(f)					
	- ()					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 71 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155377		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/14/2013		
	PROVIDER OR SUPPLIER			707 S J	ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR DUR, IN 47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F000514 SS=D	SSIBLE The facility must reach resident in a professional standare complete; accreadily accessible organized. The clinical reconsinformation to ide of the resident's accare and services	maintain clinical records on accordance with accepted dards and practices that curately documented; e; and systematically d must contain sufficient ntify the resident; a record assessments; the plan of a provided; the results of a screening conducted by ogress notes.	F00	0514	F514 RECORDS-COMPLETE/ACC ATE/ACCESSIBLE The facility repectfully requests paper revi IDR for tag F 514. The facility evidence for the following tags support the deficiencies should not have been sited. The facility must maintain clinical records each resident in accordance waccepted professional standar and practices that are complet accurately documented; readil accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident; a record of the resident's assessments; the pi of care and services provided; results of any preadmission screening conducted by the State; and progress notes. W corrective action(s) will be accomplished for those reside	y iew has s to d ty on vith ds te; y	09/06/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 72 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155377		A. BUILDING R. WING		COMPLETED 08/14/2013		
NAME OF PROVIDER OR SUPPLIER SEYMOUR CROSSING			STREET A	ADDRESS, CITY, STATE, ZIP CODE JACKSON PARK DR DUR. IN 47274		
	JR CROSSING SUMMARY S' (EACH DEFICIEN		707 S J	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPE DEFICIENCY) found to have been affected the deficient practice? *Res #96 was not harmed by the alleged deficiency practice *Resident #96 event descrip now match appropriate area body. How will you identify residents having the potentiable affected by the same depractice and what corrective action will be taken? *Resident in the facility have spotential to be affected by the alleged deficient practice. *Director of Nursing Services and/or designee will inservice nursing staff on complete an accurate documentation by September 6, 2013 *Director Nursing Services and/or dewill audit all current open exto ensure accuracy of short description. What measure be put into place or what sy changes you will make to enthat the deficient practice do not recur? *Staff will be	Department of the proof of the	(X5) COMPLETION DATE
				not recur? *Staff will be re-educated on complete ar accurate documentation up hire and ongoing thereafter *Non-compliance with facilit policy and procedure may rin employee education and/disciplinary action *Director Nursing Services and/or de will monitor for compliance *Director of Nursing Service and/or designee will pull the facility activity report and princes every morning to reviand ensure accuracy in documentation.	esult for of signee es e	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 73 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		COM	(X3) DATE SURVEY COMPLETED		
155377		B. WING		08/1	4/2013		
NAME OF PROVIDER OR SUPPLIER SEYMOUR CROSSING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAC	CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE	
	Based on interreview, the faci accurately door records in accords included. Resident #96's on 8/7/13 at 4:' indicated Residing included, but whypertension, hulcers on feet, insufficiency, distroke with here in according to the according to the according to the according to the factor of the according to the factor of the according to the factor of the factor	view and record lity failed to maintain umented clinical ordance with accepted andards and practices bserved for pressure ent #96) ed: record was reviewed 10 p.m. The record dent #96's diagnoses ere not limited to, history of recurrent peripheral venous epression, and right		corrective action(s) wi monitored to ensure the practice will not recur, quality assurance proput into place? *A Mericol will be utilized we four, monthly times two quarterly thereafter. *It submitted to the CQI of for review. If threshold achieved, an action place developed to ensure of the control of th	he deficient i.e., what gram will be dical enance CQI ekly times o, and Data will be committee d is not lan may be		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 74 of 77

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00 CO.		COMPL	COMPLETED	
155377		155377	B. WIN			08/14/	2013
		<u> </u>	b. wh		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					ACKSON PARK DR		
SEVMOI	JR CROSSING				OUR, IN 47274		
OLTWO					0013, 114 47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	•	terior scrotum". The					
	report indicated	d the wound to be					
	stage II (2) and	d originally noted on					
	3/15/13.						
	Additional ever	nt reports entitled "Skin					
		sASC Pressure					
	, ,	valuation Report",					
		•					
		at 9:38 a.m. and					
		24 a.m., indicated the					
	wound location to be "posterior						
		"date area originally					
	noted", wound	characteristics and					
	treatment plans were consistent with the pressure ulcer located on the posterior scrotum originally identified on 3/15/13.						
	0.1.07.107.10.						
	 "\Mound Team	Review" dated 3/22/13					
		ndicated, "Area to					
		•					
		ving with current					
	treatmentWill continue current treatments and monitor." Event report entitled "Skin Integrity EventsASC Pressure Wound Skin Evaluation Report", dated 4/1/13 at 7:24 a.m. and provided by the DON 8/13/13 at 11:30 a.m. indicated the location of the wound to be "posterior scrotum", with evaluation notes indicating, "area resolved." Progress notes dated 4/16/13 at						
	10:01 a.m. indicated, "IDT						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet Page 75 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
155377		A. BUILDING 00		COMPLETED 08/14/2013			
155577			B. WIN			00/14/	2013
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
SEYMOU	JR CROSSING				ACKSON PARK DR DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		ry team) met for wound					
		posterior scrotum					
		ime. Current tx of					
	·	shift will be cont until					
	4/30/13 for pre	v meas".					
	An intomicur	th I DN #12 was					
		ith LPN #13 was 3/8/13 at 1:21 p.m. She					
		dent #96 developed a					
		on his scrotum after					
	admission to the facility and that it						
	was resolved.						
	In an interview with the DON on						
		p.m., she indicated					
	Resident #96 did previously have a pressure ulcer located on his scrotum						
	· .	e a pressure ulcer on					
		e indicated that any					
		citing "sacrum" as the					
		"Skin Integrity Events					
	ASC Pressure Wound Skin Evaluation Reports" was incorrect and that any report documentation						
	•	lated to the pressure					
	ulcer on Resident #96's scrotum. The						
DON indicated, "My wound nurse							
	does the chart audits" and that she could provide "no good reason" for						
	the discrepanc						
	3.1-50(a)(1)						
	3.1-50(a)(1)						
	5 55(G)(L)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 76 of 77

PRINTED: 09/16/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155377		(X2) MULTIPLE CO A. BUILDING B. WING	00	08/14	LETED 14/2013			
	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274					
	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	707 S J	ACKSON PARK DR	ETION ILD BE	(X5) COMPLETION DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: AL8J11

Facility ID: 000272

If continuation sheet

Page 77 of 77